



State of Connecticut
Department of Social Services

W-300SA
(New 1/16)

**Medical Report
(For SAGA Cash Benefits)**

Dear Medical Provider:

The patient named on page 2 has applied for assistance with the Department of Social Services (DSS). He or she has acknowledged physical and/or mental health problems that prevent employment. Please complete the questions on this form in the space provided so we can decide whether he or she is eligible for State Administered General Assistance (SAGA) unemployability benefits. To qualify, the patient must have a severe mental or physical impairment, or a combination of impairments, that will preclude employment for at least 6 months.

In addition to completing these questions, please provide objective medical evidence, including copies of any diagnostic test results, pertaining to the diagnosed condition(s). **We cannot grant benefits without this objective medical evidence.** If you recently submitted this information to the Social Security Administration, or if your progress notes provide this information, you may substitute copies of those materials. A form W-303A, "Permission to Share Medical Information," was provided to the patient to sign so that you may release his or her medical information, but feel free to use your own authorization form if you prefer.

Please return the completed form to:

To bill DSS for your services, refer to the instructions on form W-513, "Request for Medical Payment," which was also provided to your patient.

Thank you for taking the time to provide information on behalf of your patient.

Patient Name _____

Section A. General Information

1. What conditions have you diagnosed with respect to this patient? Please include physical and psychological conditions. For each diagnosed condition, please provide the approximate date of onset.

2. Does this condition, or combination of conditions, prevent the patient from working at this time?

☐ Yes ☐ No

If no, go directly to the signature section on page 7 of this form.

If yes, go on to the next question.

3. How long do you expect that the patient will be unable to work?

☐ Less than 2 months ☐ 2 months or more, but less than 6 months

☐ 6 months or more, but less than 12 months ☐ 12 months or more

If you checked either that the patient will be unable to work “Less than 2 months” or “2 months or more, but less than 6 months,” stop. Proceed to page 7 and complete the signature section. If you checked either that the patient will be unable to work “6 months or more, but less than 12 months” or “12 months or more,” continue.

4. How long have you been treating this patient? How frequently have you seen this patient during this time?

5. List the patient's symptoms, including pain, dizziness, fatigue, etc.:

5.a. If your patient experiences pain, characterize the nature, location, frequency, precipitating factors and severity of this pain:

6. Please summarize the clinical findings and objective signs that support each diagnosis you listed above:

7. Describe the patient's response to treatment, including any side effects of medication, that may have a negative impact on his or her ability to work, such as drowsiness, dizziness, nausea, etc.:

8. What is the patient's prognosis?

Patient Name _____

9. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations? ☐ Yes ☐ No

9.a. If yes, please explain and describe how these emotional factors impact the patient's ability to work:

10. Does the patient have a problem with substance abuse? ☐ Yes ☐ No

10.a. If yes, is the patient actively engaged in substance abuse treatment? ☐ Yes ☐ No

11. For each diagnosed psychological condition identified in question 1, please list the condition and indicate whether the patient is experiencing a single episode or an exacerbation of a chronic illness (if no psychological condition has been diagnosed, go directly to question 12):

11.a. If the psychological condition is recurrent, is there a cyclical pattern? ☐ Yes ☐ No
If yes, describe the frequency of this pattern:

12. Please describe any other limitations (such as limited vision, difficulty hearing, or the need to avoid temperature extremes, wetness, humidity, noise, dust, fumes, gases or other hazards) that affect the patient's ability to work at a regular job on a sustained basis:

13. Are the patient's impairments, as demonstrated by signs, clinical findings and laboratory or test results, reasonably consistent with the symptoms and functional limitations described on this form? ☐ Yes ☐ No

13.a. If no, please explain the discrepancy:

Patient Name _____

Section B. Physical Capacities Evaluation

1. In terms of the patient's ability to perform during an 8-hour workday with normal breaks, the patient can:

Activity	Never	1 Hour	2 Hours	3 Hours	4 Hours	5 Hours	6 Hours +
Sit							
Stand							
Walk							

2. The patient can lift and carry:

Weight patient can lift	Never	Rarely (1-5% of work day)	Occasionally (1-33% of work day)	Frequently (34-66% of work day)	Continuously (67-100% of work day)
1-10 lbs.					
11-20 lbs.					
21-49 lbs.					
50 lbs. or more					

3. Does the patient have significant limitations with reaching, grasping, handling or fingering objects?
☐ Yes ☐ No

4. If yes, indicate the percentage of time during an 8-hour work day that your patient can use his or her hands, fingers, and arms for the following activities:

Hand/Arm	Grasping, turning, and twisting objects	Fine manipulation of objects using the fingers	Reaching with arms in front of body	Reaching with arms overhead
Right	_____%	_____%	_____%	_____%
Left	_____%	_____%	_____%	_____%

5. The patient is able to:

Activity	Never	Rarely (1-5% of work day)	Occasionally (6-33% of work day)	Frequently (34-66% of work day)	Continuously (67-100% of work day)
Stoop / Bend					
Crouch / Squat					
Twist					
Climb Stairs					

Patient Name _____

Climb Ladders					
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6. To what extent can the patient be involved in the following activities?

Activity	Never	Rarely (1-5% of work day)	Occasionally (1-33% of work day)	Frequently (34-66% of work day)	Continuously (67-100% of work day)
Unprotected heights					
Being around moving machinery					
Exposure to marked changes in temperature/humidity					
Driving automotive equipment					
Exposure to dust and fumes					

7. Does the patient require the use of assistive equipment, such as a cane or walker, when standing or walking? ☐ Yes ☐ No

If yes, what symptoms require the use of this assistive equipment?

☐ Imbalance ☐ Pain ☐ Weakness ☐ Insecurity ☐ Dizziness ☐ Other: _____

Section C. Mental Residual Functional Capacity Assessment

1. During what percentage of a typical workday are your patient's symptoms likely to be so severe that they interfere with attention and concentration needed to perform even simple work tasks?

☐ 0% ☐ 1-5% ☐ 6-10% ☐ 11-15% ☐ 16-20% ☐ 21-25% or more ☐ More than 25%

2. To what degree can the patient tolerate work stress?

☐ Incapable of tolerating even "low stress" ☐ Capable of tolerating only low stress
☐ Capable of tolerating moderate (normal) stress ☐ Capable of tolerating high stress

3. In each table that follows, please place a mark in the box that best describes how the patient's conditions impact the indicated function. "Not significantly limited" means the patient can consistently and usefully perform the function. "Moderately limited" means the patient's capacity to perform the function is diminished. "Markedly limited" means the patient cannot usefully perform or sustain performance of the function.

Patient Name _____

Memory and understanding

Function	No Limitation	Not Significantly Limited	Moderately Limited	Markedly Limited
Remember locations & work-like procedures				
Understand and remember very short, simple instructions				
Understand and remember detailed instructions				

Social interaction

Function	No Limitation	Not Significantly Limited	Moderately Limited	Markedly Limited
Interact appropriately with the general public				
Ask simple questions or request assistance				
Accept instructions and respond appropriately to criticism from supervisors				
Get along with co-workers or peers without distracting them or exhibiting behavioral extremes				
Maintain socially appropriate behavior and adhere to basic standards of neatness and cleanliness				

Sustained concentration and persistence:

Function	No Limitation	Not Significantly Limited	Moderately Limited	Markedly Limited
Carry out very short, simple instructions				
Carry out detailed instructions				
Maintain attention and concentration for extended periods				
Perform activities within a schedule, maintain regular attendance, be punctual within customary tolerances				
Sustain an ordinary routine without special supervision				
Work in coordination with or proximity to others without being distracted by them				
Make simple work- related decisions				
Complete a normal workday/workweek without interruptions from symptoms. IE, able to perform at a consistent pace without an unreasonable number and length of rest periods				

Patient Name _____

Adaptation

Function	No Limitation	Not Significantly Limited	Moderately Limited	Markedly Limited
Respond appropriately to changes in the work setting				
Be aware of normal hazards and take appropriate precautions				
Travel in unfamiliar places or use public transportation				

Signature Instructions

Thank you for taking the time to complete this form on behalf of your patient who has applied for assistance. Please print (or stamp) your name and sign below. We cannot accept the completed form without your signature. This form may be signed by any licensed medical provider whose scope of practice, as set forth in the Connecticut General Statutes, permits him or her to diagnose and treat the conditions for which this form is being completed. A licensed master social worker may complete this form with respect to mental health disorders, but the co-signature of a supervising physician, advanced practice registered nurse, psychologist, professional counselor or licensed clinical social worker is required.

Name of person completing this form (Print)

Title

Signature

Provider type (specialty)

License Number

Date

Name of co-signer, if required (print)

Title

Signature

Co-Signer Provider type (specialty)

License Number

Date

Telephone Number

Fax Number